TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-2273-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 28, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services. Total allowable per Medicare $6,240.32. Total payments received were in the amount of $1,601.52."

Amount in Dispute: $3,900.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's invoice for code C1763 appears to indicate the unit price was $492.00 to the facility. The bill indicates one unit. Texas Mutual paid $541.20, which is the unit price plus 10%. The requestor asserts it is $4900.00. However, the invoice does not support that assertion. No additional payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3 - 5, 2016	CPT C1763	$3,900.31	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 225 – The submitted documentation does not support this service being billed. We will re-evaluate this upon receipt of clarifying information
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 350 – In accordance with TDI-DWC 134.804, this bill has been identified as a request for reconsideration or appeal
- 723 – Supplemental reimbursement allowed after a reconsideration of services
- 897 – Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134; subchapter health facility fees

Issues

1. Did the carrier pay per the applicable fee guideline?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of CPT Code C1763 – "Connective tissue, nonhuman (includes synthetic)" provided during an outpatient hospital stay from October 3, 2016 through October 5, 2016. The carrier made a payment upon reconsideration of $541.20. The requestor still seeks $3,900.31 in additional reimbursement.

   The Division fee guideline related to implantables provided in an outpatient hospital setting is found at 28 Texas Administrative Code 134.403 (g) which states in pertinent part,

   > Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   Review of the documentation submitted with the request for MFDR was an invoice from WRIGHT Medical Technology Inc. This invoice has a description of "1 Implant Kit 1 Instrument Kit Material Calcium Sulfate, Calcium Phosphate Vol: 15cc." A unit price of $456.00 is listed by this item.

   Based on the requirements of the applicable fee guideline the manufacturer's invoice amount in this case is $456.00 plus 10% ($45.60) would equal a reimbursement of $501.60. The carrier paid $541.20. No additional payment is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 21, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.